Senate Study Bill 1193

SENATE/HOUSE FILE _____
BY (PROPOSED GOVERNOR'S BILL)

Passed Senate, Date _____ Passed House, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

An Act relating to the establishment of a critical care fund for the payment of certain medical malpractice claims and making an appropriation.
BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
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Section 1. NEW SECTION. 519B.1 DEFINITIONS.
As used in this chapter, unless the context otherwise requires:
1. "Advanced registered nurse practitioner" means a person who is licensed as such under chapter 152.
2. "Board" means the critical care fund board established in section 519B.5.
3. "Commissioner" means the commissioner of insurance or the commissioner's designee.
4. "Division" means the insurance division.
5. "Fiscal year" means the period of twelve months beginning on July 1 and ending on the following June 30.
6. "Fund" means the critical care fund created in section 519B.6.
7. "Health care provider" means a person to whom this chapter applies pursuant to section 519B.2.
8. "Medical malpractice" means a situation where a physician fails to properly treat a medical condition and the physician's negligent act or omission is the cause of a new or aggravated injury to the patient.
9. "Patient" means an individual who receives or should have received health care services from a health care provider or from an employee of a health care provider acting within the scope of their employment.
10. "Physician" means a person who is licensed under chapter 148, 150, or 150A.
11. "Principal place of practice" means either of the following:
a. A state where a health care provider furnishes health care services to more than fifty percent of the health care provider's patients in a fiscal year.
b. A state where a health care provider derives more than fifty percent of the health care provider's income in a fiscal year from the practice of the health care provider's profession.
Sec. 2. NEW SECTION. 519B.2 APPLICABILITY.
1. Except as provided in section 519B.3, this chapter applies to all of the following:
a. A physician or advanced registered nurse practitioner for whom this state is a principal place of practice and who practices in this state more than two hundred forty hours in a fiscal year.
b. A physician or advanced registered nurse practitioner who is exempt under section 519B.3, subsection 1, but who practices outside the scope of the exemption and for whom this state is a principal place of practice and who practices in this state more than two hundred forty hours in a fiscal year. For a physician or advanced registered nurse practitioner who is subject to this paragraph, this chapter applies only to claims arising out of the physician's or advanced registered nurse practitioner's practice that is outside the scope of the exemption under section 519B.3, subsection 1.

c. A partnership comprised of physicians or advanced registered nurse practitioners organized and operated in this state for the primary purpose of providing the medical services of physicians or advanced registered nurse practitioners.

d. A corporation organized and operated in this state for the primary purpose of providing the medical services of physicians or advanced registered nurse practitioners.

e. An ambulatory surgery center that operates in this state.

f. A hospital, as defined in section 135B.1, that operates in this state.

g. An entity operated in this state that is an affiliate of a hospital and that provides diagnosis or treatment of, or care for, patients of the hospital.

h. A health care facility, as defined in section 135C.1, whose operations are combined as a single entity with a hospital, whether or not the health care facility operations are physically separate from the hospital operations.

2. A physician or advanced registered nurse practitioner for whom this state is a principal place of practice but who does not practice in this state more than two hundred forty hours in a fiscal year, may elect, in the manner designated by rule by the commissioner, to be subject to this chapter. However, this chapter applies only to claims arising out of the electing physician's or advanced registered nurse practitioner's practice that is in this state and that is outside the scope of an exemption under section 519B.3.

Sec. 3. NEW SECTION. 519B.3 EXEMPTIONS FOR PUBLIC EMPLOYEES AND FACILITIES.

Except as provided in section 519B.2, this chapter shall not apply to the following:

1. A physician or advanced registered nurse practitioner who is a state, county, or municipal employee, or a federal employee or contractor covered under the federal Tort Claims Act, who is acting within the scope of the physician's or advanced registered nurse practitioner's employment or contractual duties.

2. A facility operated by any governmental agency.

Sec. 4. NEW SECTION. 519B.4 COMMISSIONER DUTIES.

1. The commissioner shall administer the fund except that the board may provide for third=party administration of the fund pursuant to section 519B.5.

2. The commissioner may adopt rules pursuant to chapter 17A as necessary to administer this chapter.

Sec. 5. NEW SECTION. 519B.5 CRITICAL CARE FUND BOARD.

1. A critical care fund board is established, and shall consist of the following members:

a. The treasurer of state or the treasurer's designee.

b. The director of public health or the director's designee.

c. The commissioner or the commissioner's designee.

d. Four public members appointed by the governor and confirmed by the senate to staggered four=year terms, except that of the first members appointed, two public members shall be appointed for terms of two years. One public member shall be a licensed attorney in Iowa with experience in the area of medical malpractice, one public member shall be an insurer based in Iowa, one public member shall be an Iowa=licensed physician, and one public member shall represent an Iowa=based hospital.

The filling of positions reserved for public representatives, vacancies, membership terms, payment of compensation and expenses, and removal of members are governed by chapter 69. Members of the board are entitled to receive reimbursement of actual expenses incurred in the discharge of their duties within the limits of funds appropriated to the board or made available from the fund. Each member of the board may also be eligible to receive compensation as provided in section 7E.6. The members shall elect a chairperson of the board from among the members of the board.

2. Management of the fund shall be vested with the board.

3. In managing the fund, the board shall have all of the general powers reasonably necessary and convenient to carry out its purposes and duties including but not limited to the following:

a. Management of the fund including the authority to retain a third=party administrator, external claims assistance, actuarial services, outside defense counsel, and other services as necessary to manage the fund.

b. Enter into contracts on behalf of the fund.

c. Adopt rules as necessary for the management of the fund.

Sec. 6. NEW SECTION. 519B.6 CRITICAL CARE FUND CREATED.

1. A critical care fund is created for the purpose of paying that portion of a medical malpractice claim that is in excess of either one million dollars for each occurrence or three million dollars for all occurrences in any one policy year or the maximum liability limit for which the health care provider is insured, whichever limit is greater.

2. Moneys in the fund shall be payable for occurrence coverage for claims against health care providers who have complied with this chapter and against employees of those health care providers, and for reasonable and necessary expenses incurred in payment of claims and administrative expenses of the fund.

3. The fund shall not be liable for damages for injury or death caused by an intentional crime committed by a health care provider or an employee of a health care provider, whether or not the criminal conduct is the basis for the medical malpractice claim.

4. The fund shall be actuarially sound and require the maintenance of surplus adequate to fund the level of the claims as set by the board.

5. The fund shall be a separate fund in the state treasury, and any funds remaining in the fund at the end of each fiscal year shall not revert to the general fund of the state but shall remain in the critical care fund. Interest or other income earned by the fund shall be deposited in the fund. Moneys in the fund shall not be subject to appropriation for any other purposes by the general assembly, but shall be used only for the purposes set forth in subsections 1 and 2.

Sec. 7. NEW SECTION. 519B.7 FEES.

1. A health care provider shall pay an annual fee, subject to the following criteria:

a. The past and prospective loss and expense experience in different types of practice.

b. The past and prospective loss and expense experience of the fund.

c. The loss and expense experience of the health care provider that resulted in the payment of moneys, from the fund or other sources, for damages arising out of the provision of medical care by the health care provider or an employee of the health care provider.

d. Risk factors for persons who are semiretired or part= time professionals.

e. Risk factors and past and prospective loss and expense experience attributable to employees of a health care provider other than licensed physician or advanced registered nurse practitioner employees.

2. The commissioner, upon approval by the board, shall by rule set the fees under subsection 1. The rules shall provide that fees may be paid annually or in semiannual or quarterly installments. A prorated portion of the annual fee and semiannual and quarterly installments shall include an amount sufficient to cover interest not earned and administrative costs incurred because the fees were not paid on an annual basis. This subsection shall not impose liability on the board for payment of any part of a fund deficit.

3. The rules shall provide for not more than four payment classifications for fees paid by physicians or advanced registered nurse practitioners and shall be based upon the amount of surgery performed and the risk of diagnostic and therapeutic services provided or procedures performed.

4. The rules shall provide for an automatic increase in a health care provider's fee if the loss and expense experience of the fund and other sources with respect to the health care provider or an employee of the health care provider exceeds either a number=of=claims=paid threshold or a dollar=volume=of claims=paid threshold. The rules shall specify applicable amounts of increase corresponding to the number of claims paid and the dollar volume of claims paid in excess of the respective threshold.

5. The rules setting fees for a particular fiscal year under this section shall ensure that the fees do not exceed the greatest of the following:

a. The estimated total dollar amount of claims to be paid from the fund during that particular fiscal year.

b. The fees set for the fiscal year preceding that particular fiscal year, adjusted by the commissioner to reflect changes in the consumer price index for all urban

consumers, United States city average, for the medical care group, as determined by the United States department of labor.

c. Two hundred percent of the total dollar amount disbursed for claims from the fund during the fiscal year preceding that particular fiscal year.

6. Fees set for the fund shall be collected by the commissioner for deposit in the fund in a manner prescribed by the commissioner by rule.

Sec. 8. NEW SECTION. 519B.8 FEE ACCOUNTING AND AUDIT.

1. Moneys shall be drawn from the fund by the commissioner only as approved and authorized by the board.

2. All books, records, and audits of the fund shall be open to the general public for reasonable inspection. Claims information shall be confidential.

3. Annually, after the close of the fiscal year, the board shall furnish a financial report to the commissioner. The report shall be prepared in accordance with generally accepted accounting procedures and shall include the present value of all claims reserves including those for incurred but not reported claims as determined by accepted actuarial principles and such other information as may be required by the commissioner. The board shall furnish an appropriate summary of the report to all health care providers covered by the fund.

4. The board shall submit a report to the general assembly and the governor on or before January 1 of each year.

5. The board may cede reinsurance to an insurer authorized to do business in the state or pursue other loss=funding management mechanisms to preserve the solvency and integrity of the fund, subject to the approval of the commissioner. The commissioner may prescribe controls over or other conditions on such use of reinsurance or other loss=funding management mechanisms.

Sec. 9. NEW SECTION. 519B.9 CLAIMS PROCEDURE.

1. A person filing a claim may recover from the fund only if the health care provider or the employee of a health care provider has coverage under the fund, the fund is named as a party in the action, and the action against the fund is commenced within the same time limitation within which the action against the health care provider or employee of the health care provider must be commenced.

2. If, after reviewing the facts upon which the claim or action is based, it appears reasonably probable that damages paid will exceed the limits in section 519B.5, the fund may appear and actively defend itself when named as a party in an action against a health care provider or an employee of a health care provider who has coverage under the fund. The fund may retain counsel and pay attorney fees and expenses, including court costs incurred in defending the fund, out of the fund. The attorney or law firm retained to defend the fund shall not be retained or employed by the board to perform legal services for the board other than those directly connected with the fund. A judgment affecting the fund may be appealed as provided by law. The fund shall not be required to file a bond in any judicial action, proceedings, or appeal.

3. An insurer or self=insurer providing insurance or self= insurance for a health care provider or an employee of a health care provider, who is also covered by the fund, shall provide an adequate defense of the fund on any claim filed that may potentially affect the fund with respect to such insurance contract or self=insurance contract. The insurer or self=insurer shall act in good faith and in a fiduciary relationship with respect to any claim affecting the fund. A settlement exceeding an amount which could require payment by the fund shall not be agreed to unless approved by the board.

4. A person who has recovered a final judgment or settlement approved by the board against a health care provider or an employee of a health care provider who has coverage under the fund may file a claim with the board to recover that portion of such judgment or settlement that is in excess of the limits set forth in section 519B.5, or the maximum liability limit for which the health care provider or employee of the health care provider is insured, whichever limit is greater.

5. Claims filed against the fund shall be paid in the order received within ninety days after filing unless appealed by the fund. If the amounts in the fund are not sufficient to pay all of the claims, the claims received after the funds are exhausted shall be immediately payable the following year in the order of their receipt.

Sec. 10. NEW SECTION. 519B.10 APPLICABILITY.

Coverage under the fund applies to settlements and judgments entered on or after January 1, 2006, with respect to occurrences taking place on or after July 1, 2005.

Sec. 11. APPROPRIATION. There is appropriated from the general fund of the state to the insurance division of the department of commerce for the fiscal year beginning July 1, 2005, and ending June 30, 2006, the sum of one million dollars to implement and administer the provisions of this Act.

EXPLANATION

This bill relates to the creation of a critical care fund.

The bill requires certain health care providers to purchase from the critical care fund, created in the bill, an excess amount of medical malpractice coverage beyond the greater of the primary medical malpractice insurance coverage amount required by statute or the maximum liability limit for which the health care provider is insured. The bill provides that the fund shall provide occurrence coverage for such excess medical malpractice claims against a health care provider and employees of a health care provider, and for reasonable and necessary expenses incurred in the administration of the fund. The fund shall not be liable for damages caused by an intentional criminal act of a health care provider or employees of a health care provider.

The bill provides that participation in the fund is mandatory unless the health care provider qualifies for an exemption, or unless a health care provider who would not otherwise qualify for mandatory participation elects to voluntarily participate in the fund. "Health care provider" is defined to include a medical or osteopathic physician or surgeon or advanced registered nurse practitioner, or a partnership of such physicians or surgeons or advanced registered nurse practitioners, a corporation providing physician or surgeon or advanced registered nurse practitioner medical services, an ambulatory surgery center, a hospital and affiliates of a hospital that provide diagnosis, treatment, or care for patients of the hospital, and a health care facility as defined in Code section 135C.1.

The bill provides that the fund shall be managed and administered by a board that consists of the treasurer of state, the director of public health, the commissioner of insurance, and four public members.

The bill further provides that the commissioner of insurance shall by rule and subject to board approval set the annual fee assessed a participating health care provider, subject to certain guidelines. The assessed fees are determined by a number of factors including the past and prospective loss and expense experience of the health care provider, the past and prospective loss and expense experience of the fund, risk factors for persons who are semiretired or part=time professionals, and risk factors and past and prospective loss and expense experience attributable to employees of the health care provider other than licensed physician employees. The commissioner is given the authority to draw moneys from the fund as approved and authorized by the board.

The bill also provides a claims procedure for a person filing a claim against a health care provider or an employee of the health care provider who has coverage under the fund.

The bill provides that the fund shall operate on a fiscal year basis from July 1 through June 30. Administrative costs, operating costs, and claim payments are funded through the assessments on participating health care provides, with an initial appropriation in the amount of $1 million from the state general fund to provide start=up moneys for the fund. The fund is also financed through earnings on the fund's investments. Annually after the close of the fiscal year, the board shall submit a financial report to the commissioner and shall submit a report to the general assembly and the governor on or before January 1.

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